Five Ethical and Clinical Challenges Psychiatrists May Face When Treating Patients with Borderline Personality Disorder Who Are or May Become Suicidal

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ABSTRACT

This article discusses five core ethical and clinical questions psychiatrists should consider when they treat patients with borderline personality disorder who are or may be suicidal. These questions include whether psychiatrists should tell patients their diagnosis, what they should tell them about their suicide risk, whether they should be "always" available by phone, when they should hospitalize these patients involuntarily, and how they should respond after these patients have attempted suicide and return for further care. This discussion highlights the ethical components of these questions. Optimal ethical and clinical interventions, in most cases, overlap. Psychiatrists may accomplish the most clinically by sharing with these patients some of the above conflicts that they face and/or the rationales for doing what they will do. These interventions may maximize the autonomy patients with borderline personality disorder and at the same time be clinically optimal, increasing a sense of self-efficacy and patient-psychiatrist trust in the patients.

KEYWORDS

Borderline personality disorder, suicide, diagnosis, telephone contact, involuntary hospitalization, ethics, patient-psychiatrist relationship, terminating treatment

INTRODUCTION

Psychiatrists may face exceptional stresses when they treat patients who have borderline personality disorder (BPS). These patients may, for example, react intensely in negative ways and these responses may be easily triggered.[1–3]

A propensity that will likely cause psychiatrists anguish, however, is BPD patients' increased likelihood of attempting suicide. Up to 10 percent of patients with BPD die by suicide,[4–8] and each patient with BPD will, on average, attempt suicide 3.3 times in his or her life.[8]

The way in which patients with BPD may endanger their lives may also be unusually agonizing, because they are especially prone to feeling rejected and then reacting with rage.[9,10] One patient, for instance, just after being released from an inpatient ward, went to her car and took all her prescribed medications. She then called the ward and told them that she had done this, but would not tell them where she and her car were. Fortunately, hospital personnel did find her in time to save her life.

In the past, psychiatrists have been inclined to regard the

prognosis of BPD patients pessimistically. Yet recent findings have shown that patients with BPD respond much better to treatment than had been thought. Patients with BPD may do better not only with, but even without, psychiatric treatment.[9–14] Further, it is also now known that general psychiatrists can treat most patients with BPD successfully, even if they have not had extensive, specialized training.[4,9,15,16] Basic approaches for general psychiatrists have been published.[9,17,18]

Because most psychiatrists can treat patients with BPD effectively, all psychiastrists should know the core concepts for treating patients with BPD. One set of such core concepts, and perhaps the most important, is what psychiatrists should do when patients with BPD are or may be suicidal. This article reviews five of the most important ethical and clinical challenges in this area that are likely to arise.

1. TELLING PATIENTS ABOUT THEIR DIAGNOSIS

A core question arising at the beginning of treatment is what psychiatrists should tell patients regarding a diagnosis of BPD.[4,5,12] This question has plagued psychiatrists in the past. This was, it would seem in large part, because of their belief that this disorder had such a negative prognosis. The word *borderline* also came to have negative connotations, although in 1938 when it was first used, it was meant merely to refer to patients who had neither a "psychosis" nor what psychiatrists then called a "neurosis," but, rather, a diagnosis somewhere in between.[12]

Until recently, psychiatrists have accordingly often feared sharing the diagnosis of BPD with their patients.[9] In addition to concern regarding negative reactions from a patient with BPD, particularly when the patient feels abandoned, some psychiatrists have feared that their sharing this diagnosis could convey stigma, impair their subsequent patient-psychiatrist relationship, and/or even squash patient hope.

Now, however, it is known that patients with BPD can, in general, do better if psychiatrists share this diagnosis.[4,9,12] As one group of psychiatric experts in this area say, "It is now less common to hide the diagnosis from the patient, and borderline personality disorder (BPD) has become a useful label to guide the treatment process and help the patient make sense of his or her suffering."[12]

After having shared the diagnosis, in addition, psychiatrists can also share that the interpersonal problems most patients with BPD have are partly genetic and due to differences in their brains that render them more likely to respond more strongly to interpersonal stress.[9,15,19,20] This information may have an immediate beneficial effect on both patients and their family members.[9] This knowledge may, for example, relieve patients of a lifelong sense of guilt or shame at having believed that what has gone wrong in their personal relationships is wholly and solely their fault.[4,9,21,22]

Ethically, psychiatrists' sharing with patients this diagnosis respects them more by informing them to a greater extent. Patients with BPD are likely to do better with the now more optimistic information psychiatrists have given them. This may also increase the patient's trust in his or her psychiatrist.

Some psychiatrists go over with patients with BPD each of the nine diagnostic criteria now used for making the diagnosis of BPD.[9] As they read through each criterion together, it gives the patient the opportunity to respond by saying, "Yes, that sounds like me!" Thus, the patient actually may end up essentially diagnosing him- or herself.

A patient I was seeing for depression had looked up borderline personality disorder on the internet and then asked me whether I thought she had this disorder. I told her that I thought that clearly she did not, but that I would be happy to review the criteria with her if she thought it would be helpful. I then added that even if she did have this disorder, reviewing the criteria might be good because the problems she was having might be ones we could treat.[23]

Perhaps the greatest gain a psychiatrist can expect from sharing the diagnosis and information on BPD with patients is that it may give the patients justified new hope. Recent work suggests that for many suicidal patients, hope may be as important, if not more important, than anything else.[22]

2. DISCUSSING INCREASED RISK OF SUICIDE

In all psychotherapies, it is generally important for psychiatrists to help patients have realistic expectations.[9] Because patients with BPD are exceptionally likely to attempt suicide, a question this risk factor raises is whether psychiatrists should tell their patients about this increased risk.

Ethically, disclosing risk demonstrates respect for the patient and may result in increased trust. On the other hand, disclosing might be harmful to the patient. For example, it might possibly decrease a patient's hope for recovery or possibly even become a self-fulfilling prophecy. A patient so informed might, for example, be at the brink of taking his or her life and then be more likely to believe that his or her therapist

expects a suicide attempt.

Psychiatrists could share this dilemma with patients with BPD. They could say, for example, that they want to share this information with the patient so that they can face this increased risk together. The psychiatrist might also add that he or she fears this information might have a negative effect on the patient by reducing his or her hope. The psychiatrist could then explore with the patient how he or she is responding to this information.

These considerations may raise the closely related ethical and clinical question of whether psychiatrists should ask patients with BPD to agree to and perhaps sign antisuicide contracts. Some psychiatrists believe that these contracts help reduce a patient's suicide risk; these contracts may, for example, make it harder for a patient to attempt suicide when he or she has already agreed not to. Others psychiatrists may feel, however, that requesting this agreement may decrease a patient's trust.

Having such a contract, however, is never a guarantee. Patients may attempt suicide regardless of what they have previously said. As other experts in treating patients with BPD say, "All recommendations regarding no-harm contracts are expert opinions, as minimal empiric evidence exists."[5]

Psychiatrists may want to consider whether to share this dilemma with patients. In other words, they would like, on one hand, for the patient to reap the gains from making a nonsuicide agreement while, on the other, not losing his or her trust in the psychiatrist. In this context, the psychiatrist may consider telling the patient with BPD that whether her or she attempts suicide or not is ultimately the patient's responsibility. This is no doubt true because the psychiatrist cannot protect the patient all of the time. However, by telling this to the patient, the psychiatrist risks infantilizing the patient or causing the patient to feel that the psychiatrist is "talking down" to him or her by telling the patient what he or she already knows. Thus, although opening the discussion of suicide in this manner may help some psychiatrists feel better, it may at the same time decrease their patients' trust of them.

Suicide is a real risk that neither the patient nor the psychiatrist may be able to escape. By sharing this risk and discussing it openly, the psychiatrist and the patient can bear this fear together when they must. Over time, it is hoped this fear will diminish.

3. DECIDING WHEN THE PSYCHIATRIST SHOULD BE AVAILABLE FOR PHONE CALLS

Psychiatrists should discuss early on with their BPD patients what the patients should do if they feel suicidal. A specific question is the extent to which the psychiatrist will be available by phone. Psychiatrists may be available, for example, day or night or only during office hours.

If a psychiatrist allows his or her patients to call him or her only at certain times (e.g., when at work in the office), the psychiatrist should tell them when, in general, they can expect to be called back. Psychiatrists should also tell patients what they should expect when called back.

Psychiatrists may believe that they should say little more than what patients should do to be "safe," although this may only reiterate what they have told them before. Psychiatrists may believe they should only do this rather than try to "talk them down." If during an emergency call, a psychiatrist only plans to tells a patient how to be safe, the psychiatrist should tell his or her patients this in advance and provide a reason why. Having this discussion with patients beforehand may prevent the patients from feeling rejected later if ever they make an emergency call to the psychiatrist.

Psychiatrists may be aware of how their own feelings play a role in what they do—thus posing the question of how much a psychiatrist should should self-disclose to his or her patients. Not being available day and night may help to reduce a psychiatrist's stress. Likewise, not taking on the responsibility, and thus not assuming the potential risk of "failure," of trying to talk patients down when in a suicidal situation may also reduce a psychiatrist's stress. Should the psychiatrist ever share these feelings with their patients, particularly patients with BPD? Or would this be considered unwise?

Another problem of being on-call for patients day and night is that some patients may call too often. One approach, and a dangerous one, is to ask patients before they call to decide on their own if their suicidal feelings are "serious." If a patient lacks the capacity to make this decision but decides not to call so as to not trouble the psychiatrist, that patient may be more likely to take his or her own life.

Patients with BPD may, paradoxically, be at higher risk of attempting suicide when they are less depressed. They may have more energy to make the suicide attempt.[24] Yet if they feel pressure from their psychiatrist to not call when they feel that they may be at risk, they may not call at these times because they feel less desperate but are, in fact, at higher risk.

In these situations, it is better for the psychiatrist to take these types of

calls and to help his or her patients decide what to do at these times. The psychiatrist can then discuss the decisions and the "problem" of being on-call round the clock with his or her patient with BPD later when the patient feels better.

4. HOSPITALIZING PATIENTS WITH BPD INVOLUNTARILY

A possibility psychiatrists should also consider exploring early on when treating patients with BPD is what a patient should expect if the psychiatrist believes that he or she should be hospitalized but the patient disagrees. There are many factors that may increase a patient's imminent risk to him- or herself or to others. For example, there are subtypes among those who have BPD who are at significantly higher suicidal risk.[6,25,26]

The psychiatrist might discuss with the patient the possibility that the psychiatrist is more informed and that the patient, when under stress, may be less able that the psychiatrist to assess what he or she needs most. This may help later, in that both the psychiatrist and the patient may agree early on that there may be times with regard to the decision to hospitalize when the psychiatrist could "know best."

Psychiatrists may unduly fear legal liability. In one study, 85 percent of clinicians acknowledged at some time having done what they thought was best for themselves as opposed to what they believed was best for a patient.[27]

This ground for hospitalizing patients when in doubt is, however, flawed. Psychiatrists risk far greater legal liability when they act to protect themselves, as opposed to when they act based on what they believe will be best for a patient. A psychiatrist's best protection is to consult with colleagues and to then document what they together decide.[28]

Ethically, it is now known and well recognized that when patients are chronically suicidal they may do better if not hospitalized in spite of their remaining at some risk.[7] Psychiatrists treating patients with BPD should carefully consider all other options.[9] One such patient I saw, for example, adamantly opposed going into the hospital, so we agreed that I would call her, initially, at various times throughout the day. We did this, and the frequency with which we had to talk decreased rapidly, and in fact, much more rapidly than I had expected. She did well without being hospitalized.

A core ethical challenge psychiatrists should consider discussing with their patients is the notion that a means of increasing a patient's safety in the short run may not be best for the patient in the long run. Patients with BPD and their psychiatrists should discuss this concern openly early on in treatment.

5. WHAT PSYCHIATRISTS SHOULD DO AFTER PATIENTS HAVE ATTEMPTED SUICIDE (AND "FAILED")

Psychiatrists differ in regard to how they should respond if patients with BPD, as other patients, attempt suicide and fail. Some psychiatrists will continue to treat the patient, whereas others will not. For example, one patient called her psychiatrist and told him that she was in a bathtub filled with water and holding her electric hair dryer, which was turned on, inches above the water in her hand. She agreed to not end her life then but to see him later in his office. She did. He then told her that she needed to go into the hospital and that, in any case, their outpatient work together was "over."[29]

Psychiatrists should consider discussing with their patients what they would do if a suicide attempt occurred and, most importantly, why. The psychiatrist may fear that if he or she indicates early on that he or she would still see the patient, that the patient might find it easier to try to end his or her life. Psychiatrists who indicate initially that they would continue treatment help to dispel a feared risk that so many patients with BPD face, especially early on in treatment—namely, that the patients will be abandoned and left all alone. Thus, this understanding may help reassure the patient that his or her psychiatrist both cares for the patient and expects the patient to get better as they discuss this joint fear together.

When patients attempt suicide but fail, psychiatrists should assess whether they themselves have failed, i.e., that their skill may be insufficient to give the patient what he or she needs. Whereas most psychiatrists with basic skills in treating patients with BPD may treat most of them successfully, sometimes this clearly is not the case. Psychiatrists may consider discussing with the patient in advance the possibility, in the event of a suicide attempt, of transferring the patient to another physician. This discussion may "normalize" for the patient that this transfer may occur, if indeed this need comes about. The patient then will have time to process and accept this alternative possibility of being transferred to another physician and hopefully will be less likely to see this as an outright rejection.

Psychiatrists should be aware that they might wrongly or prematurely conclude that they lack sufficient skills to treat a patient who has attempted suicide, and thus refer a patient to someone else because it will be best, emotionally,

for the psychiatrist. They may also wrongly transfer a patient in response to guilt. Again, in this situation, psychiatrists should seek out assistance from trusted colleagues to help sort out these feelings and questions.

Ultimately, psychiatrists should attempt to convert a suicide attempt by a patient with BPD to the patient's benefit. They may explore with the patient, for example, the interpersonal responses that may have triggered the attempt. The psychiatrist should bear in mind that these responses may include things the psychiatrist did or said.

To reiterate, psychiatrists should consider discussing with their patients beforehand what they would do in the event of a suicide attempt. Having this discussion at the beginning of treatment may help patients become hopeful early on in treatment. Psychiatrists indicating that they would be willing to continue to see patients even after they attempt suicide and that they would use it as a rare opportunity to learn about what had occurred so that it would be less likely to happen again connote strongly the therapist's expectation that the patient will do better.

CONCLUSION

Psychiatrists have often felt reluctant to treat patients with BPD. This has been due in large part to beliefs that have now changed. We know now, for example, that patients with BPD, especially with treatment, can get better, and that most psychiatrists have the skills that can help most patients with BPD.[9,17,18]

We know that the problems of patients with BPD often result from interpersonal "oversensitivity" resulting, at least partially, from structural and/or genetically caused factors. By sharing this knowledge, psychiatrists may help may patients with BPD and their families have greater understanding about why they experience the difficulties they experience.

The knowlege of psychiatrists of how they may help may also give warranted new hope to their patients with BPD. A psychiatrist's greatest source of reluctance to treat patients with BPD in the past may have reflected fear that the patient would attempt suicide. As a group, patients with BPD are more likely to attempt suicide than many groups of patients with other psychiatric illnesses, but with optimal basic knowledge and appropriate responses by the psychiatrist, this suicide risk may be successfully managed, if not reduced.

This article reviews five difficult questions psychiatrists may confront when they treat patients with BPD who are or may become suicidal. These questions range from those at the beginning of treatment to some that arise after patients with BPD have tried unsuccessfully to commit suicide. The discussion emphasizes both the gains for a psychiatrist treating patients with BPD and the possible gains for a psychiatrist discussing with patients some of these questions. It proposes that the latter discussion, ethically, may respect patients with BPD more by informing them, especially about the uncertainties underlying their treatment. These discussions also may benefit patients directly by involving them more in their own care.

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